CLINICAL MEDICINE

VOL. 57 APRIL, 1950 NO. 4

Original Articles

Editorials

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A much wider range of therapy in biliary tract disorders is provided by combining dehydrocholic acid and natural bile salts in a single preparation. Such a preparation is HYDRO-BILEIN. Each tablet contains 2 grs. dehydrocholic acid and 2 grs. dried fresh ox bile. Indications for this two-way therapy are many: to flush out the bile passages and thus retard ascending infection of the biliary tract; to improve the digestive powers of the dilute bile; to reduce the possibility of cholesterol or fatty acid precipitation in the bile; to assure that bile salts enter the intestinal tract following cholecystectomy; to increase intestinal motility in constipation. The average dose is one tablet two to four times daily, preferably after meals. Dosage may be reduced if it produces an undesired laxative effect. Sugar-coated HYDRO-BILEIN Tablets are available at all pharmacies in bottles of 100 and 1000. ABBOTT LABORATORIES, North Chicago, Illinois.

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Entered as Second Class Matter August 1, 1942, at the Post Office at Wilmette, Illinois, under Act of March 3, 1879.

Editorials

The Injured Hand and the "DO SOMETHING DOCTOR"

The fate of the injured hand rests with the first doctor who treats it.

There is a human tendency to "do something" now, at once, usually in a hurry and without preparation—yet the patient may pay for that carelessness the rest of his life in a stiff or useless finger or hand.

Homer Dudley has well written of the "somethings" that one may be tempted to do, and we quote from *Western Journal of Surgery, Obstetrics and Gynecology:*

1. Grab bleeding vessels with any available unsterile hemostat. It is an emergency and the control of hemorrhage is one's first duty.

2. Tie bleeding vessels with, say about No. 4 catgut. Leave the ends long. Catgut seems to slough out faster than silk.

3. Don't put the patient to any unnecessary expense. Operate in the back office, without gloves and with mouth and nose uncovered. Masks fog one's glasses and it is hard enough to see divided nerves and tendons with the wound half full of blood. One can always tell the patient how dirty the wound was and why infection followed.

4. Inject something into the wound or use nothing. Anesthetics are expensive. Tell the patient to be brave, it doesn't amount to much. A helpful term is "Don't be a baby."

5. Never use a tourniquet, it might cause "wrist drop." If you can't identify nerve and tendon ends, what's the difference. You can sew them to something. That's the "do something method."

6. Don't debride contaminated or devitalized itssue, it takes time and after all, one can't stay up all night on one case of "minor surgery," or miss office hours and disappoint ambulatory patients.

7. Don't suture divided nerves, they are awfully small and hard to find. When the disabling and painful neuromata form, tell the patient it's the scar that causes the pain and everyone knows if one gets cut, there is bound to be scar. That's nature's cure.

8. Be sure to tell the patient everything was "all chewed up" and you had to hurry because he went bad under the anesthetic.

9. After dabbling around for a while, most of the time spent in sponging, to get a hit and run peek at the unidentified structures, one may be amazed to find there isn't

enough skin to cover the exposed nerves, tendons and joints. Well, hell's bells! it isn't your fault. You didn't give him the injury. You are just the doctor giving service late at night when you would rather be home in bed. So, what to do? Here comes science and the "Do Something Method."

Don't waste any time in sliding skin flaps or making skin grafts. Rely on science and modern methods. Pour the wound full of some highly colored, well advertised chemical dope, the brighter the color the better. It's known as "wound rouge." This impresses the patient, particularly when operated upon under local anesthesia and indicates that modern scientific methods have been employed as commonly used in this community.

10. Fill the wound with "All Purpose Powder." Put in enough so there won't be a single spot where a streptococcus can find squatter's right to locate. Mortal man can do no more. Refer the patient to *Reader's Digest* or Medical Section of *Time* magazine. Of course, one can't flush the wound with sterile saline solution, that would wash out all the "Star Dust" to which one's hope is anchored.

11. When possible, always make vertical incisions along the volar surface of the digits with special attention to crossing flexion creases. As scars tend to contract, this will give a splendid and useful hook-effect to the digit.

12. Don't hurry to operate on these patients within the safety period of four to six hours. They haven't anything else to do now but get cured and they will be laid up for a long time anyway. Put them aside until the s l i g h t l y relaxed perineum, chronic endocervicitis and so-called chronic appendix cases are cared for. They have had to wait a long time for a cure and have economic and chronologic priority. After all, one can't show favoritism to patients or invading organisms.

It seems by now everything has been done as commonly employed in this community so one may as well quit and hurry home. Leave the dressing to an intern who may have just had his first experience in the treatment of a seriously injured hand. Tell him to cover the wound with gauze, fingers extended and adducted, thumb adducted on a plane with the metacarpals and all lightly bandaged. Don't use a compression dressing, it might cause pain and cut off circulation. Apply a straight board splint, holding the hand, all digits and wrist in malposition. Don't dismiss the patient from the hospital because he will probably need sedation for five or six days and dressings once or twice a day after the fourth day. Remember one may make additional charges for dressings when the wound is infected. No fair minded patient would expect the doctor to render this service for nothing and assume the additional expense.

Under the "Do Something Method" it is now time to shoot the patient full of something; penicillin, gas bacillus antitoxin and tetanus toxoid and then labor under the delusion that the injured person has been rendered a service for which you have a right to collect a large fee, because it was a serious case and happened in the middle of the night or can be charged to some insurance company. If it is a State Industrial Insurance case, bill the Department of Labor & Industries five or six times above what the printed fee schedule provides, and then complain because the bill is reduced 50 per cent or more, probably much less than it should have been with respect to functional results.

Which New Medical Book Do You Need?

The average physician is baffled by the flood of medical books. He asks these questions of himself, as he reads advertisements for and looks over books at conventions: Do I really need this book? Is it written for my field of interest and ability? What does it cover? Is it theoretical or usable?

Clinical Medicine, as has every other medical journal, published a book review column which gave in great detail every title and position of the author, and a reviewer's lengthy opinion of the book.

Clinical Medicine's review column, because of the number of books published and the length of the reviews, was months or even a year behind date of publication. This is also true of other publications. (Frank Lahey has mentioned that one journal reviewed a book two years after publication).

Often, because of the reviewer's bias, carelessness or haphazard method, the physician still could not tell the answer to his questions, under the old system.

New Method of Review

Now, *Clinical Medicine* publishes in columns the name of the book, the author, the publisher, the price, to which type of physician the book is of interest, and a brief comment, within a month or two of the time that the book is received. The physician can glance down the columns and tell at once if the book is usable to him, and if usable, roughly, what the purpose of the book is.

Exceptional books will, in addition, be reviewed at length after an interval of time.

We feel that in this way the physician can learn about new books at once, the publisher receives a fair deal by prompt notice of his books and the outstanding book receives recognition. We would appreciate comments from physicians and publishers.—R. L. G.

Do Lay Publications Dictate Your Practice?

Physicians have been reporting, over the years, that patients read articles in lay magazines and criticize physicians if the treatment is not used immediately upon them.

The use of Vitamin E in the treatment of heart disease is a case very much in point. A number of Canadian physicians used Vitamin E in the treatment of various forms of heart disease and reported sensational results. These results were never reported in complete, scientific studies, but rather in brief reports in little known medical journals. No other physicians confirmed its value. Some of the weekly news magazines spurred the story that Vitamin E was practically a cure-all for heart disease. Dr. Herbert Eichert of Miami, in the August 1949 *Southern Medical Journal* points out "in spite of the devious value of this drug, its wide-spread use continues. The perpretation of this nostrum upon a gullible public is a reflection of the influence which lay publications exhibit in medical practice. A small group of physicians were able to force thousands of other physicians to treat cases of heart disease with Vitamin E, by presenting their opinion to the public by the lay press, before they had been corroborated."

He Who Wins Need Not Explain

"Keep in mind the happy ending. Many lay greater stress upon the rules in the way to an end than upon the happy attainment of that end: and yet the shame of failure has always outweighed any approbation of pains taken in accomplishment. *He who wins, does not have to explain.*"

"Most men see nothing of the means to an end, but only the good or bad issue thereof: and so none endangers his reputation who accomplishes his end. A happy finish gilds everything, however unfitting the means may have been. Which explains why at times it should be the rule to offend the rules, when it is not possible by other methods to attain a happy ending."

These cynical phrases are not those of a communist leader, although they well could be. They were written four hundred years ago by the Spaniard, Baltasar Gracian, as a portion of the book, "A Truth-telling Manual and Art of Worldly Wisdom."*

The Art of Living

In life, we must decide what we want and how we are to attain that end. Will that desire and its fulfillment in years to come bring us happiness? Does the end justify the means?

Life is a question to which there is no answer, no simple answer. In contrast to Gracians philosophy, one may well appose that of William Osler. Osler, a shining light of medicine and of humanity, felt that a physician should do each day's work well and not concern himself about the tomorrows.

Happiness comes in doing well what we can, now. The future, envisaged as a great shining dream, may never come for us, or worse, it may come and the dream be shattered by its realization. But today, here and now, we can help other people, and attain happiness. Happiness never comes to him who works for it alone.—R. L. G.

*Translated by Martin Fischer. Published by Charles Thomas, Springfield, Illinois.

No medical man can afford to neglect the art of questioning and the art of listening.—Sir E. Farquhar Buzzard, M.D.

Histoplasmosis vs. Tuberculosis

The recent work on lung calcifications as found in children and nurses in the Mississippi Valley adds force to the contention of Myers and the Minneapolis group that the tuberculin skin test is an essential part in the diagnosis of tuberculosis. It also weakens the argument of the radiologists who would base the campaigns for the discovery of foci of infection by tuberculosis on mass x-ray examinations. At least, one should conclude that all those children and adolescents who show x-ray evidence of calcifications should be skin tested.

That the need for continuing the campaign against tuberculosis is shown by the mortality statistics in several states in the reports in the *Statistical Bulletin of the Metropolitan Life Insurance Company*. These show that some states are not lowering their death rates as rapidly as their neighbors. The interesting thing about these states seems to be the complacency of their tuberculosis associations.

We doctors should keep pushing both the official and unofficial agencies to keep on their toes in this fight to eradicate tuberculosis. — G. H. Hoxie

Diagnostic Error:

Sarcoma

By JAMES F. BRAILSFORD, M.D.
Radiologist, Royal Cripples and Queen Elizabeth Hospital,
Birmingham, England

Discussion

The author has seen several cases of sarcoma of the limbs in which prompt surgery or radiation has not prevented early death with pulmonary metastases. In at least two cases, biopsy of the local lesion reported inflammatory changes only. He has discussed this in an article, "Sclerosing Sarcoma of Bone (Dangers of Biopsy)", *British Journal of Radiology*, 8-10, January 1945.

A six year old girl developed a painful swelling over the right upper arm. A diagnosis of sarcoma with multiple metastases was made upon the following findings: 1. Blood count of 10,375 white blood cells per cu.mm. (segmented polymorphonuclear neutrophils 56 per cent, nonsegmented polymorphonuclear neutrophils 0.5 per cent, lymphocytes 36 per cent, eosinophils 3.5 per cent, basophils 0.5 per cent, myelocytes 3.5 per cent); red blood cells 4.59 million per cu. mm., hemoglobin 90 per cent, Hematocrit 36.2 per cent. Reticulocytes 2.4 per cent; X-ray of the right arm and chest: "Marked changes in the diaphysis which has fractured off the upper half of the humeral shaft. The disintegration of the bone and the periosteal reaction are indistinguishable from osteomyelitis, but there are multiple rounded secondary lesions in the lungs. These certainly suggest the diagnosis of sarcoma . . ." (See Fig. 1).

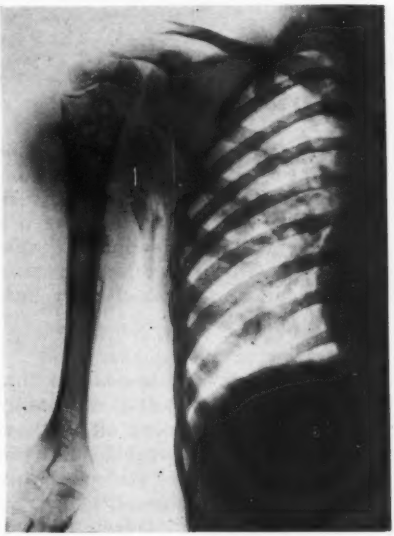

Figure 1—Sarcoma

Treatment and Course

The arm was put into a short plaster cast and sulphathiazole (0.25 gm.) was administered every 4 hours for five weeks. After two months there was progression of the disintegration of the humerus, progressive development of multiple rounded lesions throughout the lungs (See Fig. 2) and a general worsening of the patient's clinical condition. After the third month, however, there was evidence of improvement which continued to complete recovery. At the end of six months, X-rays of arm and chest were normal.

Diagnosis

Unfortunately no biopsy was taken of the lesion. It is unlikely that it

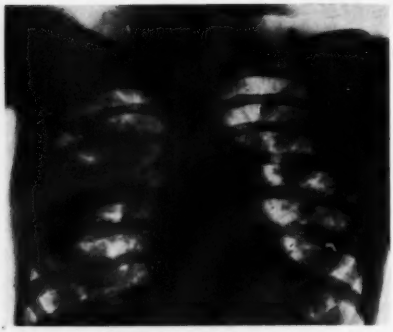

Figure 2—Sarcoma

was an osteomyelitis with multiple pulminary infarcts since both organs healed completely without residuals. The lesion may have been a reticulo-endothelial granuloma (xanthomatosis, lipoidgranuloma, eosinophilic granuloma) which can heal without leaving any scar.

Discussion

The interest of this case is that sarcoma was diagnosed repeatedly by competent observers, all of whom gave a hopeless prognosis, but not one of whom obtained a biopsy. Only the lesions in the lungs with their presumably hopeless prognosis saved this patient from amputation of the arm. It must be emphasized that aborted osteomyelitis from any cause may be associated with roentgen changes which may be mistaken for sarcoma.

The finding of one lesion must not be considered as the final answer, i.e. a case of abdominal distress in which gallstones were demonstrated; later study revealed a carcinoma of the splenic flexure of the colon.

Feces in the rectum have been mistaken for a tumor of the pelvis. Food residues in the stomach or intestines have been mistaken for malignant disease. The shadow of the biceps muscle projecting over the chest has been considered a localized empyema. A bilateral empyema was considered to be shadows due to breasts. Misinterpretation of the shadow of the hyoid bone, which projected over the angle of the mandible, for a sarcoma, has been made. Mumps has simulated the appearance of a tumor of the mandible.

In many cases, the x-ray findings are not definite and clear cut. The clinician has often been told what the radiographs would show but not what they would not show.

There is a "latent" period during which a lesion will give no x-ray appearances and the clinician will be misled if he relies entirely upon the film. Radiographic signs lag behind clinical signs as can be determined by examination, at intervals, of patients with avascular necrosis of the head of the femur after fracture, reduced dislocation, acute osteomyelitis, subperiosteal hematoma, pneumonia, tuberculosis, fractures and so on.

Bacteriology of Eye Infections

In practical office bacteriology cultures are centrally reserved for:

(1) Chronic conjunctivitis
(2) Chronic blepharitis
(3) Recurrent chalazia
(4) Unusual or resistant types of acute infections
(5) Cornear ulcers

A cotton swab moistened with broth is touched to the conjunctiva and then immediately inoculated upon blood and mannitol agar. The lid is cultured separately.—Frederick H. Theodore, M.D.

Treatment of Obesity

By S. G. SCHMIDT, M.D.
Chicago, Illinois

Obesity, one of the most common metabolic irregularities, is estimated to be present in 1 out of every 5 adults in the United States. Obesity is defined as an exaggeration of the normal process of fat storage. McLester[1] states that an excess of 25 per cent over the individual normal definitely constitutes obesity.

Pathologic Conditions Associated with Obesity

The statistics of life insurance companies show that obesity tends to shorten the life span, and many investigators have observed pathologic conditions associated with excessive weight, such as an unusually high incidence of varicose veins, diseases of the joints (mostly of the knees and ankles) and hypertensive cardiovascular disease in obese persons. The mortality rate from cardiovascular diseases is some two and one-half times greater in overweight persons than in those of normal weight. There have been noted in obese patients a tendency toward the development of diabetes mellitus and a predisposition to gallbladder disease, gout and chronic bronchitis. Obesity constitutes an additional risk in surgery.

Classification and Causation

In accordance with Beardwood's[2] differentiation of types, obesity may be classified as follows:

1. Exogenous (due to hyperalimentation)
2. Endogenous—
   (a) Endocrinopathic origin (dysfunction of the pituitary, adrenals or gonads)
   (b) Nervous origin (due to injury or disease of the diencephalon)
   (c) Hydrolipomatous (defect in salt-water metabolism, but not "true obesity")

Conceptions of various authors with respect to the causes of obesity vary widely. Some attribute all cases of obesity to overeating, others stress psychosomatic or heredofamilial factors.

Dietary Treatment

Whatever the contributing factor, obesity could not be present without excessive ingestion of food, either absolute or relative. It follows, therefore, that successful treatment of obesity can be achieved only with dietary restriction.

Effective management of obesity depends on the solution of several therapeutic problems:

1. Appropriate reduction diets
   (a) Low Caloric—(b) High protein—(c) Low carbohydrate—(d) Low fat—(e) Low salt—(f) Large bulk diets, supplemented with vitamins or iron-liver preparations if required.

2. Maintenance of the patient's will to adhere to the diet
   (a) Psychotherapy (encouragement)—(b) Medication (anorexigenic preparations)
3. Correction of endocrinopathic disorders (mostly hypothyroidism and hypogonadism)

Reducing diets, with respect to caloric values, should be adjusted to individual requirements. Most reducing diets permit between 600 and 1,500 calories a day. Wohl allows an intake of about 20 calories daily for each kilogram of ideal body weight, while McLester[1] limits the daily ration to 30 to 50 per cent below the calculated maintenance figure.

The therapeutic objective of reducing diets consists in eliminating by oxidation excessive body fat while protecting the body proteins. Proteins not only possess a high specific dynamic action but are more easily oxidized than carbohydrates. It follows that reducing diets must be high protein diets. McLester recommends 1.5 to 1.7 Gm. of proteins per kilogram of calculated ideal body weight. Lean meat, fish, eggs, milk and cheese provide excellent sources of proteins of high biologic value.

In order to preserve the nitrogen balance, at least 50 per cent of the energy provided by the diet should be supplied by carbohydrates, preferably in the form of fruits and vegetables, to insure an acid base equilibrium, to avoid the dehydration of acidosis or the hydrophilic tendencies of the tissues in alkalosis. The fat level in reducing diets should be very low; 20 to 30 Gm. of fat meet all biologic requirements and insure full utilization of fat-soluble vitamins. Reduction of salt intake to 2 to 3 Gm. a day, is also recommended.

To alleviate the feeling of hunger so common with restrictive diets, as well as to minimize constipation, reducing diets should contain a maximum of bulk, provided by green vegetables and fruits. Their content of mineral salts and vitamins may be supplemented with polyvalent vitamins and, in cases of secondary anemia, with iron-liver preparations.

The best selected diet, however, will fail to produce results as long as the patient is unwilling, or lacks the determination, to adhere to it. Many patients are reluctant to diet because of their fear of ensuing weakness or other detrimental effects. Others do not have the will power necessary to override temptation. Explanation and education by the physician is helpful, and encouragement and proper psychotherapeutic approach often bears fruit.

Adjuvant Therapy

Anorexigenic Drugs. Obese patients, in the opinion of many well qualified authorities, should be granted the benefit of a "crutch," in the form of anorexigenic drugs, in conjunction with a restricted diet. Chemically, most accepted appetite depressants are aminopropanes. Their pharmacologic action causes (1) a depressing effect on gastric motility due to hunger (relaxation of the stomach and increase in the tone of the pylorus), (2) a stimulating effect on the central nervous system and (3) a temporary rise in the metabolic rate. Most aminopropanes begin to produce these effects in twenty minutes to one hour after oral administration, lasting six to twelve hours. In a few cases the duration has been up to thirty-six hours. In therapeutic doses, aminopropanes may affect the blood pressure, pulse rate and respiratory rate; however, the changes, if they occur at all, are only slight and temporary.

The delay in emptying time of the stomach causes a sensation of fullness after ingestion of moderate amounts of food; it reduces the feel-

ing of hunger and eliminates the craving for food, thus enabling the patient to adhere to a restricted diet without feelings of self-sacrifice and self-pity. Gradually the stomach adjusts itself to the limited charge; it shrinks, and the patient may remain free from hunger sensation on a limited diet even after anorexigenic medication has been discontinued.

The stimulating effect of anorexigenic compounds on the nervous system manifests itself in elevation of mood, a sense of increased efficiency and intensification of the urge to work. Fatigue is decreased and sleepiness is counteracted.

These reactions are of real benefit to the obese patient inasmuch as they combat the let-down feeling frequently experienced in reducing regimens. Furthermore, they help maintain full working capacity and fortify the patient's determination to adhere to the restrictive diet.

Side Effects: The most commonly encountered side effects from treatment with aminopropanes are dryness of the mouth and constipation, the latter as the result of the relaxing effect of the aminopropanes on the bowel. Insomnia has been observed in some cases when the drug was given too late in the afternoon. There have been some reports of mild tachycardia, hypertension and elevation of the metabolic rate after administration of single large doses. Some patients exhibited a sense of exhilaration for a few days, and some hypersensitive patients reported a sensation of apprehension, depression or exhaustion. There have also been some complaints of headache, dizziness, halitosis, burning in the throat and heartburn. Nausea and vomiting have been reported as toxic reactions in hypersensitive patients or after excessive doses of anorexigenic compounds. These reactions could be controlled efficiently by decrease in dosage.

Contraindications: Contraindications for treatment with aminopropanes are relatively few. The drugs are definitely contraindicated in persons with hypersensitivity to ephedrine-like drugs; they should not be given to patients suffering from insomnia, pronounced excitability and excessive restlessness. Marked coronary impairment and conditions in which vasoconstrictors may not be used are also contraindicants. In cases of advanced hypertension or cardiovascular disease, great caution in treatment with aminopropanes should be exercised. Few cases of habituation to anorexigenic drugs have been reported; nevertheless, the possibility, however remote, should be borne in mind.

Thyroid Therapy: A considerable number of obese patients show signs of hypothyroidism. However, a low basal metabolic rate alone does not always indicate a thryroid deficiency; metabolic rates as low as 20 per cent have been reported in normal persons. Cautious thyroid medication, starting with small doses, will bring the basal metabolic rate to a normal level. It has been clinically demonstrated that small amounts of thyroid can be given many obese patients with normal metabolism, with good reducing effect and without harmful side action. The diuretic action of thyroid has a definite bearing on water retention in obese patients. Close medical supervision in all cases of thyroid medication is absolutely essential, and the patient should be kept on a restricted diet.

Compounds Investigated

As mentioned previously, most anorexigenic drugs are aminopropanes. The first compound extensively investigated was amphetamine sulfate. It has a long record of efficiency and

low toxicity. The average dose is 5 to 15 mg. given three times a day, one-half to one hour before meals. The dose should be individually adjusted, and the preparation should not be given later than 4 p.m., because of possible interference with sleep.

In those cases in which endocrine disorders are the basic cause of obesity, correction of the glandular dysfunction should be attempted. In hypogonadism, treatment with gonadotropins or gonadal hormones may produce results.

New Reducing Compound

The trend in recent years has been in favor of combining the anorexigenic action of amphetamine drugs or amphetamine-like substances with the calorigenic and diuretic action of thyroid. Most of these reducing compounds contain varying amounts of phenobarbital to counteract such undesirable side effects as increased nervousness, hyperirritability and insomnia. These appetite depressing compounds are designed as adjuncts to restrictive diets.

One of the newer reducing compounds* contains amphetamine hydrochloride, thyroid and phenobarbital, in three different combinations.

It has been under clinical investigation for some time, and its dosage, mode of administration, efficacy, effect on blood pressure and pulse rate and its side effects and toxicity have been studied in 100 unselected cases.

*Lakobie—Pharmaceutical Distributors, Inc. Chicago, Ill.

Summary and Conclusions

1. Obesity is caused by overeating in the vast majority of cases.
2. Obesity is a danger to health and longevity.
3. Efficient reduction in weight cannot be achieved without restrictive diets.
4. Anorexigenic compounds have a definite place, *under watchful supervision,* in the treatment of obesity in conjunction with reducing diets.

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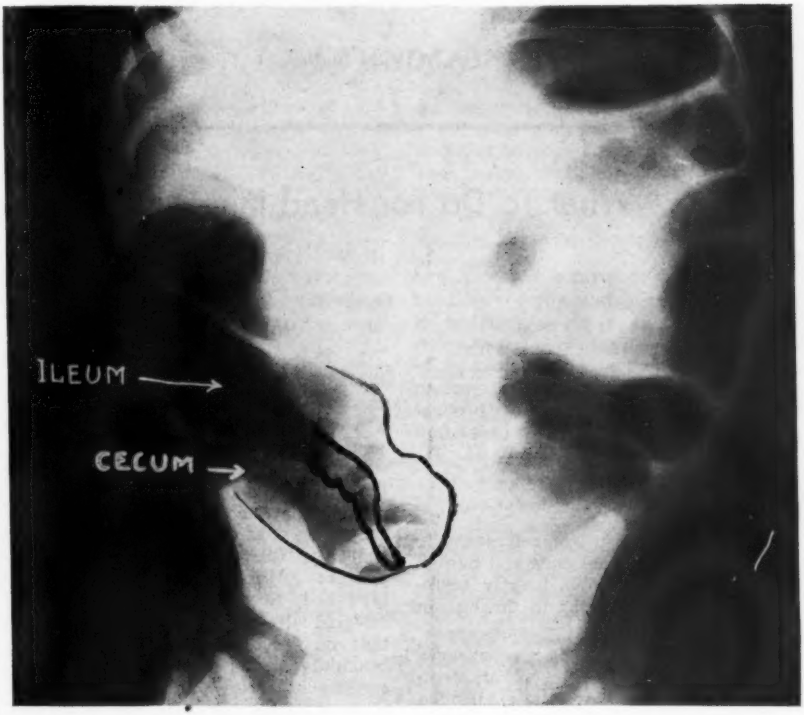
Avocations and Culture

A productive avocation is the hall-mark of the cultured man. Culture argues a broad outlook on all problems, and such an outlook is particularly demanded at the present time for a wise guidance in the trend of advance, which the medical profession is just now called upon to furnish.—Dr. John A. Hartwell.

The "Acute Abdomen"
INTUSSUSCEPTION OF ILEUM

(Joseph Levitin of San Francisco well summarized the value of simple or "flat" abdominal x-ray in diagnosing acute abdominal conditions, in *Clinical Medicine* for March 1950. Because of lack of space, his many interesting cases could not all be published at once but are being presented serially.—Ed.)



Case Number 2

This patient was a female infant of 6 months, who had been perfectly well until 3 days before entry. At this time, intestinal colic appeared. On the day of entry, the child was in considerable pain. A mass was palpable in the right lower quadrant. The white blood count was 7,900 of which 82 per cent were polymorphonuclear cells. The x-ray of the abdomen shows a distended loop of bowel in the right lower quadrant within which was a smaller loop of bowel with a narrow neck. The remaining small bowel was distended with gas. Diagnosis: Intussusception of the ileum into the colon followed by mechanical obstruction of the small bowel.

A barium enema was given but did not reduce the intussusception. At operation, the diagnosis of intussusception was confirmed. It was reduced and the child made an uneventful recovery.

(CONSULTATION SERVICE)

What To Do For Head Injuries

Question:

I am located on a main highway, and as a result, see a fair number of head injuries. What is a *proven* method of treatment? The literature is full of references to dehydration, rest, lumbar puncture and so on, with much discussion thereto, so that the facts are not brought out clearly. Am I overlooking cases that the neurosurgeon could help? M. D., Missouri.

Answer:

The literature is full of references to experiments on normal dogs and human beings, which cannot be directly correlated with injured brains in the human being.

Russell Meyers, chief of neurosurgery at University of Iowa School of Medicine, Iowa City, Iowa, has challenged much of the traditional concepts and has proved by clinical work on human beings who have suffered head injuries that:

1. One must rule out, in *severe* brain injuries, the presence of depressed fractures of the skull, epidural or subdural hematoma and large intracerebral clot, all of which may be amenable surgically. The only positive way to perform this is by introducing air into the ventricular system in amounts of 40 to 60 cc. through a lumbar needle or directly through a ventricular needle until ventricles are filled. Following *precise* x-ray studies give *positive* evidence concerning the need for surgical procedures.

2. Those which are not severe and those in whom surgical intervention is not possible are treated by (a) moderate Fowler's (head of bed elevated) position with patient turned to the side and patient is rolled from one side to the other, log fashion, regularly to prevent hypostatic congestion; (b) chloral hydrate, bromides, paraldehyde or bariturates for sedation; (c) mechanical restraint to prevent further injury, e.g. with crib type bed, twisted sheets, cuffs and so on—pad all bony prominences and see that no traction is made against the brachial plexus; (d) simultaneous recording of rectal and axillary tempertures a 2 hour intervals, for at least 36 hours following the injury; a rectal temperature above 102° F indicates brisk rubbing of the skin with warm wet cloths followed by fanning, or if necessary by 1 or 2 liters of cold water colonic instillation, until the temperature falls below this level—never below 100° F axillary temperature, never rapidly and always stopped promptly if cyanosis appears; (e) a long intestinal tube, such as a Levine, is passed through the nose for the purpoe of introducing magnesium sulphate in three ounce doses, and for giving liquids and foods, so as to

maintain fluid and nutritional balance without intravenous injections.

Meyers has also shown that much of the material that has grown up around the concepts of "increased intracranial pressure" together with heroic attempts at dehydration by hypertonic intravenous injections does not withstand study.

Even more important, he has demonstrated that *neurologic signs and symptoms may indicate that a lesion is present but does not permit one to make an exact diagnosis as to its type or whether it may be aided by surgical intervention.* Also, that most brain injuries are multiple in nature, and that the simple or pure lesion (e.g. clot, laceration, edema) is uncommon.

The Possible Case of Meningitis

Question:

What should one do about the case of early or very mild meningeal involvement? It is not uncommon to find a patient with slight stiffness of the neck, a little fever and malaise. What is the best treatment depending upon the spinal fluid findings, i.e. clear, cloudy or purulent? I am 100 miles from a competent laboratory and farther from a hospital that takes contagious patients, so wish to send away only those who will be really helped by specialized treatment.—M.D., Nebraska.

Answer:

If headache, especially severe and persistent headache, appears one must forget about upper respiratory disease and think of meningitis or meningoencephalitis; other infections, such as rickettsial and infectious mononucleosis, also cause headache. Drowsiness and repeated vomiting also suggest meningeal irritation, if cranial injury can be ruled out.

Clear fluids found on spinal fluid examination usually do not call for emergent treatment, unless polymorphonuclear cells are found, which may indicate very early bacterial meningitis. Meningitic signs may result from involvement of poliomyelitis, lymphocytic choriomeningitis, encephalomyelitis or mumps.

Turbid fluids call for immediate therapy; spinal fluid examination and blood culture should be taken. If a skin rash is present also, meningococcus meningitis is almost certainly present and 5 Gm. of sulfadiazine must be given intravenously with 1,000 cc. of physiologic saline, 300,000 units of penicillin given intravenously and intramuscularly.

If no rash is present, pneumococcal or streptococcal infection may be present, especially if mastoiditis, sinusitis or head injury has preceded. H. influenzae meningitis cause a turbid fluid in infants and small children; it should be treated with streptomycin, sulfadiazine and if needed, H. influenzae antibody serum intravenously.

Treatment of Hiccups

Question:

What can be done for a patient of 34 who has persistent hiccups which respond only temporarily to sedatives and usual treatment? M.D., Washington, D.C.

Answer:

We have used Benzedrine in a number of cases of hiccups with very good results.

Benzedrine-Sulfate (Amphetamine) a five mg. dose has proven satisfactory, but I have given 10mg. doses. It is sometimes necessary to give a sedative if the Benzedrine is given after 3 p.m. In two cases I gave one c.c. amp. of Benzedrine Sulfate as the initial dose. Each c.c. contains 10 mg. of amphetamine Sulfate in sterile, isotonic, aqueous solution. Contains no preservative. This is a Smith, Kline and French preparation.

My experience has been that one or two days medication is sufficient, but I have given it for three days in two and three cases.

A Tired, Nervous Patient

Question:

A lawyer's wife, aged 48, complains of tiredness, gas, loss of appetite, nervousness and irritability and feels like crying at times. She has difficulty in getting to sleep. She has steady headaches, at the occiput, which never wake her up. Nothing interests her, she has stopped her hobbies and sees less and less of her friends. She says she finds it hard to remember things, but she can easily remember unpleasant experiences. She is worried about her weakness, worries about tuberculosis and cancer. Two internists and the Mayo Clinic have worked her up thoroughly from a diagnostic standpoint, without finding anything organically wrong. I suppose this is psychoneurotic but what type and can anything be done? A.S., M.D., Chicago.

Answer:

This is a typical description of involutional melancholia, in its earlier stages. Later, depression, fears, hallucinations, agitation and thoughts of suicide appear. Treatment with estrogens is often ineffective. Don't tell the patient that "nothing is wrong"; don't tell the patient to get a change by taking a vacation or a trip, as they may commit suicide while away and the trip will not help them anyway, as the trouble is inside. Don't treat them at home. Don't have them on the upper floor of the hospital, as the suicidal impulse may come at any time.

Electric shock therapy is almost specific for such conditions. The patients respond dramatically. Also, the patient must be given "permission to have symptoms" (Gordon Kamman, University of Minnesota, Minn.). Usually, these patients feel that they are accused of being frauds, and feel that they are not understood.

Neck Pain

Question:

Quite a number of patients have tender areas at the base of the neck, in the occipital region on each side of the cervical spine and the small muscles. I find this on routinely examining the neck of every patient who complains of headache. Does every such patient have occipital neuralgia? What is the cause and what can be done for it? Good temporary results follow use of heat (infrared rays electric pad, diathermy, counterirritants) or massage, but is there any permanent cure?—M.D., Columbia, Missouri.

Answer:

Tender painful neck muscles result from 1. abnormalities in the head, 2. emotional tension and 3. local myalgias.

Wolff showed that experimental pain in the head was followed by contraction of the head and neck muscles. A foreign body in the eye reflexly caused contraction of head and neck muscles and caused secondary pain and abnormal sensations in scalp and neck. Eye muscle strain caused a sustained contraction in the neck muscles, followed by shoulder and neck pain. Migraine, sinusitis and emotional pains in the head were followed by continued contractions of head and neck muscles.

Wolff states, "The common tension headache found in tense, aggressive and frustrated people was associated with prolonged contraction of head and neck muscles, which were tender to palpation. . . . Injections of 1 per cent procaine solution into the tender areas eliminated untoward head sensations. Reduction or elimination of tension by modification of life situation and administration of phenobarbital reduced or eliminated muscle contraction, pressure or tight sensations and headache."

Treatment: First look for causes of pain in head (eyes, sinus, throat), second see what kind of patient you are dealing with, third remedy any cause found in one and two, and fourth, localize very tender areas and infiltrate with 1 or 2 per cent procaine solution. This will dramatically relieve pain. If it recurs look again for tension or organic disease in the head or neck.

Death Following Intravenous Thiamine (Vitamin B_1)

Question:

Is the intravenous injection of thiamine a safe procedure? I note the clinical reports of death following the intravenous injection of 50 to 100 mg. of such vitamin B_1.—M.D., Byron, Illinois.

Answer:

Letters addressed to authorities brought these replies. From A. C. Ivy, distinguished physiologist at University of Illinois: "I saw one such collapse after 50 mg., whch occurred after the fifth injection of 50 mg. It was a cardiovascular reaction, anphylactoid in type. The injection should be made very slowly. In that way, serious consequences may be avoided."

C. C. Pfeiffer, head of the department of pharmacology, writes, "There have been several instances in the literature of respiratory death occurring from the rapid injection of large amounts of thiamine. This confirms the animal observatons of Unna, also Smith, et al."

"Since 50 mg. of thiamine given intravenously will completely saturate the body insofar as needs of this vitamin are concerned, we believe it would be advisable to suggest that intravenous injection be limited to this amount, given slowly."

"Insofar as the curare action of thiamine is concerned, we know that it is much less potent than that of d-tubocurarine, and thus chances of human fatalities occuring from the intravenous injection of 50 mg. would be exceedingly rare."

Leukoplakia of the Vulva

Question:

A patient with white patches of the vulva, apparently leukoplakia of the vulva, age 35, has had vulvectomy recommended to her by a gynecologist, to prevent cancer development. She has tried estrogen treatment by injection and local application with only temporary relief and no change in areas. Is there any other treatment that might be of help? She is young for vulvectomy.—M.C., New York City.

Answer:

Robert Crossen of St. Louis suggests large doses of vitamin A, according to the method of Hyams and Bloom: 250 to 500,000 units daily and injections of 50,000 units twice weekly, plus 15 minims of dilute hydrochloric acid in water three times daily.

Painful Joint Following Injections

Question:

Occasionally, I note a patient will have a painful joint following an injection of liver extract or mercurial diuretic (as Salyrgan or Mercuhydrin) or a vaccine for arthritis. Is this an allergic reaction? The pain and swelling of the joint usually disappears within a few days and leaves no disability or physical or x-ray signs.—M.D., Peoria, Illinois.

Answer:

When a patient has an acute "arthritis" develop after an injection, think at once of an acute attack of gout which has been precipitated by the injection. Liver extract, salyrgan, gynergen for migraine, bacterial vaccines for suspected rheumatoid arthritis, trauma, surgical procedures, rapid reduction in weight, overeating and overdrinking, overexertion or over athletics, any of these factors may produce an acute attack with a hot, bluish-red edamatous joint, in hours to days after the etiologic agent has acted. (W. K. Myers, M.D., Assistant Professor of Medicine, George Washington University School of Medicine, 1834 Eye Street, N.W. Washington, D.C.).

The diagnosis can be dramatically proven by the use of colchicine, in doses of two 1/100 gr. tablets every 2 hours for 4 doses, and then 1 tablet every 2 hours until relief is obtained or nausea and diarrhea occur.

Thumbnail Therapeutics

Treatment of Acute Renal Insufficiency

Acute kidney insufficiency and anuria are being too heroically treated. Conservative therapy of the following nature may be continued for 8 to 10 days, during which time most cases will spontaneously improve: Fluids are administered almost exclusively by mouth to replace insensible loss plus other eliminated fluid (1,000 cc. plus fluid in vomitus, stool and urine). Subcutaneous administration of solutions is resorted to if food cannot be tolerated by mouth. Rarely is any other fluid than blood given by vein, thus the patient is in no danger of being killed by circulatory embarrassment following the injection of large amounts of fluids intravenously. A protein-free diet is given.

Daily serum chloride and carbon dioxide contents are determined, and sodium chloride and sodium bicarbonate given orally to combat acidosis. Such patients remain comfortable, free of edema and heart strain, despite a progressive rise in blood urea nitrogen.—A. P. Fishman, M.D. (Michael Reese Hospital, Chicago) in *J.A.M.A.*, Feb. 12, 1949.

Carotid Sinus Syncope or Fainting

Three common mechanisms for the carotid sinus syndrome are: (1) Cardiac inhibition, the commonest mechanism, with a response of from decided slowing of the heart to complete asystole; (2) Vasodepression, a decided drop in blood-pressure with or without cardiac inhibition; and (3) the Cerebral type, with spontaneous or induced syncope without significant slowing of the pulse, or drop in blood pressure. Mixed forms may occur. —S. Weiss and J. P. Baker. *Medicine* 12, 297, 1949.

Carcinoma of the Female Breast

Advanced carcinoma of the female breast may be treated with diethylstilbestrol and result in definite regression of the lesions in one-half of the patients. —R. A. Huseby, Division of Cancer Biology, University of Minnesota, Minneapolis in *Bull. Univ. Minn. Hosp.*, Jan. 21, 1949. In advanced cases involving the bony skeleton, these therapies may be palliative: X-ray: For lesions involving weight bearing areas and for those in which the involvement is localized to a few treatable areas. Testosterone for those in which the skeleton is widely involved and those in which the lesions have not responded satisfactorily to x-ray. Oophorectomy may be indicated in younger women who are menstruating regularly, plus x-ray therapy to weight bearing bones, if involved.

Penicillin Aerosol

The chief causes for failure with penicillin aerosol in the treatment of respiratory tract infections are (1) infrequency of administration, (2) failure to augment the effect by the parenteral administration of penicillin, (3) and failure to recognize and correct underlying factors. One may not anticipate favorable results in infections which are not due to penicillin susceptible bacteria.—A. R. Hollender, *South Med. J.* 42, 57, Jan. 1949.

Treatment of Otitis Media in Children

Sulfadiazine in doses of 1 grain per pound of body weight per day, opening the ear drum if pus forms, aqueous nose drops to open internal drainage of the ear, are of value in otitis media in children or infants.—*J. Missouri M.A.*, 194

Diagnostic Pointers

Myocarditis in Infectious Diseases

Myocarditis is a common accompaniment of infectious diseases, including rheumatic fever, typhoid fever, meningococcal infections, streptococcal pharyngitis and scarlet fever, mumps, diphtheria, pneumococcal pneumonia and other infections, measles and poliomyelitis.

Diagnosis: First sound at apex becomes poor in quality and weak, tachycardia appears and a drop of 20 mm. or more in blood pressure occurs. A gallop rhythm may occur. Apical systolic murmurs may or may not be important. Electrocardiographic changes occur very frequently, with changes in the T wave in unipolar and chest leads, PR interval prolongation and prolonged QT interval.—Henry Brainerd, M.D. in; *Medical Staff Conferences*, University of California Medical School, San Francisco, Feb. 1949.

Hypertension

When a patient is discovered with hypertension, examine for pulsations in femoral arteries. If not present, suspect coarctation of the aorta. Have the patient stoop or bend forward and look for pulsations of collateral arteries on back or sides of chest (these dilated intercostal arteries are visible when bending forward, as this widens the intercostal space).—H. D. Adams, M.D. in *J.A.M.A.*, Feb. 5, 1949.

Cerebral Hemorrhage

Neurosyphilis should be suspected in every case of apparent cerebral hemorrhage. —Handbook for Physicians, Venereal Disease Education Institute, Raleigh, N.C.

The Retarded Child: Amentia or Dementia?

Amentia means lack of mind and has a hopeless prognosis. Dementia means the more or less loss of a good mind once present and the prognosis can be good. Psychotherapy is of real value in such retarded children, to remove, anxiety, fear, hate and guilt.—Stanley Cobb, M.D. in *Amer. J. Med.*, Dec. 1948.

The Sick Baby — Syphilis?

Suspect congenital syphilis in babies that "won't gain", in babies with skin rashes and snuffles, on babies born of syphilitic mothers; perform a darkfield examination on lesions. —Handbook for Physicians, Venereal Disease Education Institute, Raleigh, N.C.

Pneumonia in Older Persons

"Pneumonia" in a person past 45 may be the first sign of pulmonary carcinoma. Recurrent pneumonias over a period of 12 to 15 months indicates an underlying cause. Bronchiectasis, lung abscess or unresolved pneumonia is first diagnosed and only later is the obstructive cancer recognized. — A. Behnrend, M.D. in *Postgrad. Med.*, Jan. 1949.

Heart Complications Due to Gallbladder Disease

Anginal pains and cardiac irregularities are often due to gallstones and chronic cholecystitis. Removal of the gall-bladder relieves such patients and improves cardiac function.—W. Walters, M.D. (Mayo Clinic) in *Texas S.J.M.*, Jan. 1949.

BOOK REVIEWS

Any book reviewed or listed in these columns will be procured for our readers if the order, addressed to CLINICAL MEDICINE, 1232-36 Central, Wilmette, Illinois, is accompanied by a check for the published price of the book.

Atlas of Oral and Facial Lesions

By Ralph Howard Brodsky, D.M.D., Consulting Oral Surgeon, Department of Hospitals, New York City; Lecturer in Stomatology, New York University Graduate School of Medicine. 1948. Williams and Wilkins Co. Price with 100 color slides $80.00.

A new technic has been developed in teaching—the patient is brought to the physician in his office or home, where he can study at leisure. Pathologic entities in the region of the mouth and face are shown in accurately colored, well photographed colored slides for projection.

The author not only includes the more serious lesions, such as neoplasms but poisonings, vitamin deficiencies, allergic reactions, oral aspects of blood dyscrasias, and infections both acute and chronic. The physician who can recognize these varied forms of disease is well prepared for diagnosis in the orofacial region.

The discussions are brief and fact filled, so that the physician can grasp the essence of knowledge concerning each condition.

Electrocardiography and Clinical Disorders of the Heart Beat

By the Late Sir Thomas Lewis, C.B.E., F.R.S., M.D., Physician in Charge, Department Clinical Research, University College Hospital, London; Honorary Consulting Physician, Ministry of Pensions; Consulting Physician, City of London Hospital. Shaw and Sons, Ltd., Fleet Street, London, E.C. 4, England, 1949. 25/ net. approx. $3.50.

The consolidation of the two earliest and most authoritative books on graphic registration and clinical recognition of abnormal heart rates and rhythm is a joy to the clinician. The author realizes the value of electrocardiography but is not bound to it, as are lesser clinicians who have grown up since the EKG became dominant. Clinical judgment is expressed on every page, with correlation of clinical factors and the making of a complete, correct diagnosis.

The Physician's Daily Record

Kersten Publishing Company, Ft. Dodge, Ia., 1950. $7.50.

For many years, your editor has used this daily record of patients and its unique end-of-the-month and end-of-the-year summaries of income and expenses, with entire satisfaction. Income tax examiners who have checked it, approve of it.

Atlas of Obstetric Technic

By Paul Titus, M.D., Obstetrician-Gynecologist, St. Margaret Memorial Hospital, Pittsburgh, C. K. Mosby. 1949.

The second edition elaborates upon the original unique presentation of technic in illustrations. Gratifyingly, many minor conditions are presented which are a problem to young physicians but which are slighted in more pompous tomes. Newer technics, both of surgery and anesthesia, are pictured and briefly described. Sterility is also considered.

The Complete Pediatrician

By W. C. Davison, M.D., Professor of Pediatrics, Duke University School of Medicine, Durham, N.C. Sixth Edition. Duke Univ. Press, 1949 $4.75.

A usable text that can be employed every day in the office, dispensary or hospital, it makes no attempt to be long-winded but rather to briefly present the essentials in diagnosis and treatment. It contains the hundreds of facts that are so easily forgotten, which symptoms and signs are diagnostic, which laboratory signs are in the normal range, which feeding preparation contains what and so on. If you care for babies or children, you will use this book constantly.

Physical Signs in Clinical Surgery

Demonstrations of Physical signs in Clinical Surgery. By Hamilton Bailey, F.R.C.S., Surgeon, Royal Northern Hospital, London, Eng. Williams and Wilkins. $9.00.

This, the eleventh edition of the best clinical teaching text, presents a number of new, colored illustrations. It is ideal for the man who cannot absent himself for a brush up course in clinical surgery, because it is practical, it is easy to grasp and it stimulates better diagnosis. Hundreds of diagnostic pointers are described and pictured.

British Surgical Practice

General Editor: Sir Ernest R. Carling, F.R.C.S., Consulting Surgeon Westminster Hospital and J. Paterson Ross, M.S., F.R.C.S., Director of Surgical Clinical Unit, St. Bartholomew's Hospital, London, Eng. Vol. 5, C. V. Mosby. $15.00.

Volume five continues the fine standards set by its predecessors in this English set. It is good to see that possible surgical excision of a large set of nodes or of the spleen is advocated in a few selected cases of Hodgkins disease. Surgical intervention is decried in impotence. Denervation of the kidney is strikingly portrayed.

Atlas of Roentgenographic Positions

By Vinita Merrill, While Educational Director, Picker X-Ray Corporation. Two volumes. C. V. Mosby Co. 1949. $30.00.

Two beautifully bound volumes make easier handling and usage in the x-ray room, rather than one large book. The technics illustrated range from the most commonplace and commonly used, i.e. that of the finger to cerebral pneumography.

The newcomer and general practitioner who only occasionally x-rays less commonly injured parts of the body will find full details, together with photographs of the patient in position, reproductions of the resultant film and sketches. The experienced radiologist and his technician will find that a number of methods are given for radiographing every portion of every body part and system.

This set, when placed in the x-ray room, is used regularly—that is the final test of a book's usefulness.

Current Therapy 1949

Howard F. Conn, M.D., Editor. W. B. Saunders Co. 1949. $10.00.

A large, beautifully printed book presenting modern day trends as written by the authorities themselves. These compact methods of treatment are of great value to the physician who does not keep up with the literature, or who can find no way to file references for use in the future. The descriptions are short, yet sufficiently adequate for the indicated technics to be followed.

NEW MEDICAL PUBLICATIONS

TITLE *Author* Publisher — Price	OF INTEREST TO	COMMENTS
HYPERTENSION *By Irvine Page* Charles Thomas—$2.25	Your Patients	Living with hypertension
MANUAL FOR ATHLETES *By Voltmer & Voltmer* C. V. Mosby Co.—$3 00	All Athletes	Simple direct suggestions
A YEAR WITH OSLER *By Joseph Pratt* John Hopkins Press—$4.00	Diagnosticians	Direct case histories
NATIONAL HEALTH SERVICE ACT (ENG.) The Practitioner—$2.00	All Physicians	A year of socialized medicine
INTRAMURAL HANDBOOK *By Voltmer & Lapp* V. C. Mosby Co.—$3.00	Physical Educators	Planning school athletics for all
PATHOLOGY OF TUMORS *By R. A. Willis* Butterworth (London)—$20.00	Surgeons Pathologists	Neoplasms made clear
NEW HOPE FOR THE HANDICAPPED *By Howard Rusk* Harper & Brothers—$3.00	Disabled persons	Inspiring rehabilitation
SEX FULFILLMENT IN MARRIAGE *By Groves & Groves* Emerson Books Inc.—$3.00	Married persons	Toward normal sex relations
MEDICAL WRITINGS OF ANON. LONDINENSIS *By W. H. S. Jones* Cambridge University Press—$2.75	Medical Historians	Notes by medical student (200 A.D.)
CLINCAL ENDOCRINOLOGY *By Martin & Hynes* Blakiston Co.—$4.50	General Practitioners Students	Brief, Clinical Endocrinology
NUTRITIONAL ANEMIA SYMPOSIUM Gould Research Foundation—$"?"	Hematologists	Deficiency anemias etiology, therapy
HOW LIFE IS HANDED ON *By Cyril Bibby* Emmerson Books Inc.—$2.00	Parents Children	Wise, interesting on "life begins"
THE NEW YORK ACADEMY OF MEDICINE *By Van Ingen* Columbia University Press—$10.00	Medical organizations	One hundred years of the societies' progress
FUNDAMENTALS OF OTORARYNGOLOGY *By Boies* W. B. Saunders Co.—$6.50	General Practitioners Students	Clear, short, practical

BOOK REVIEW

TITLE *Author* Publisher — Price	OF INTEREST TO	COMMENTS
DIGITALIS & OTHER CARDIOTONIC DRUGS *By Eli Movitt* Oxford University Press—$5.75	Internists	Review of pharmacolgic & physiological medicines
CLINICAL BIOCHEMISTRY *By Cantarow & Trumper* W. B. Saunders—$8.00	Students Clinicians	Lab.—clinical correlations
ADVANCES IN INTERNAL MEDICINE *By Dock & Snapper* Interscience Press—$8.50	Internists	Pre-clinical & clinical studies
METABOLISM AND FUNCTION *By Nachmanson* Elsevier Co.—$7.00	Physiologists Biochemists	Muscle, nerve and drug action
FROM THE HILLS *by Zahorsky* C. V. Mosby—$4.00	Pediatricians Oldsters	Recital of author's life events
PDR: PHYSICIANS DESK REFERENCE *J. Morgan Jones* Medical Economics—By request	All Physicians	Quick reference to all drugs
ESSENTIALS OF OBSTETRICS & GYNECOLOGIC PATHOLOGY *By Faulkner and Douglass* V. C. Mosby—$8.75	Gynecologists Pathologists	Pathology for student and surgeon
OPERATIONS OF GENERAL SURGERY *By Thomas Orr* W. B. Saunders Co.—$13.50	Surgeons General Practitioners	Essentials; pictures modern technics (all branches)
ELECTROCARDIOGRAPHY: DISORDERS OF HEART BEAT *By Sir Thomas Lewis* Shaw and Sons—$3.50	Cardiologists General Practitioners Internists	Abnormal heart beats, recognition, treatment. Good clinical judgment
JAUNDICE *By Eli Movitt* Oxford University Press—$5.75	Internists	Liver physiology, pathology, clinical syndromes
PHARMACOLOGY, TOXICOLOGY OF URANIUM COMPOUNDS *By Voegtlin & Hodge (2 vols.)* McGraw Hill—$10.00	Atomicists Pathologists Pharmoclogists	Uranium compounds fluorine, hydrogen fluoride; pathological physiology. Nuclear energy
CARE OF THE SURGICAL PATIENT *By Jacob Fine* W. B. Saunders—$8.00	Surgeons Internists	Surgico-medical interrelations, clinical, physiologic
HEMATOLOGY *By Willis Fowler* Paul B. Hoeber—$5.00	Internists General Practitioners	Blood disorders, diagnosis and therapy; transfusions
TEXTBOOK OF PHYSIOLOGY *By John F. Fulton* W. B. Saunders—$10.00	Physiologists Internists	Physiology as the basis of medicine; authoritative
TEXTBOOK OF SURGERY *By Christopher* W. B. Saunders—$10.00	Surgeons General Practitioners	Practical surgery
FUNDAMENTALS OF INTERNAL MEDICINE *By Yater* Appleton Century Co.—$12.00	Students	Well arranged material clearly phrased
PRACTICAL OBSTETRICS *By Mayes* Australian Pub. Co.—$12.00	General Practitioners Students	Obstetrics as it is
TEXTBOOK OF NEUROPATHOLOGY *By Ben Lichtenstein* W. B. Saunders Co.—$9.50	Neurologists Pathologists	Anatomic approach; Good pictures
DERMATOLOGIE (German Text) *By J. Darier* Grune & Stratton—$25.00	Dermatologists	Didactic. comprehensive